
Principal℠
Life insurance
Take steps today to secure tomorrow
Your insurance policy has arrived.

BB10636A-03

TERM LIFE INSURANCE POLICY. Benefits payable at the death of the Insured prior to the Policy Expiration Date and while this policy is in force. Premiums are level during the Initial Level Premium Period. After the Initial Level Premium Period, premiums generally increase annually until the Policy Expiration Date, subject to guaranteed maximums. This policy is renewable to the Policy Expiration Date and renewal premiums are payable during continuance of the policy. There is a Conversion Privilege as described in the policy. This policy is non-participating.

This policy is a legal contract between You, as owner(s), and Us, Principal National Life Insurance Company, a stock company. Your policy is issued based on the information in the application and payment of premiums as shown on the Data Pages. We will pay the benefits of this policy in accordance with its provisions.

RIGHT TO EXAMINE POLICY. IT IS IMPORTANT TO US THAT YOU ARE SATISFIED WITH THIS POLICY. IF YOU ARE NOT SATISFIED, YOU MAY RETURN YOUR POLICY TO EITHER YOUR AGENT OR OUR HOME OFFICE WITHIN TEN DAYS OF THE DATE YOU RECEIVED IT. IF THIS POLICY IS A REPLACEMENT POLICY, YOU MAY RETURN YOUR POLICY TO EITHER YOUR AGENT OR OUR HOME OFFICE WITHIN 30 DAYS OF THE DATE YOU RECEIVED IT, OR SUCH LATER DATE AS MAY BE REQUIRED BY APPLICABLE LAW IN THE STATE WHERE THE POLICY IS DELIVERED OR ISSUED FOR DELIVERY. IF YOU RETURN YOUR POLICY UNDER THIS PROVISION, WE WILL REFUND ANY PREMIUM PAID. YOUR POLICY WILL THEN BE CONSIDERED VOID FROM ITS INCEPTION AND THE PARTIES SHALL BE IN THE SAME POSITION AS IF NO POLICY HAD BEEN ISSUED. PLEASE READ YOUR POLICY CAREFULLY SO YOU MAY BETTER USE ITS MANY BENEFITS.

For any questions regarding this policy, please contact Your agent or Our Home Office at 1-800-247-9988 or www.Principal.com.

This policy starts on the Policy Date and will stay in force until the earlier of the Policy Expiration Date shown on the Data Pages or death of the Insured so long as You satisfy the requirements outlined in Your policy.

Secretary

President

State Department of Insurance: NEW HAMPSHIRE
(603) 271-2261

TABLE OF CONTENTS

A copy of the application and any additional benefits provided by rider follow the last page of this policy.

Principal National Life
Insurance Company
Des Moines, Iowa 50392-0001

DATA PAGES

Term Life Insurance

POLICY DATA

Policy Number:	4855776
Owner(s) Name:	George T Campbell III

For additional owners or subsequent ownership changes, see application or letter(s) of acknowledgement.

Insured's Name:	George T Campbell III
Insured's Risk Class:	Super Standard Nontobacco
Insured's Age and Gender:	50 , Male
Policy Date:	October 21, 2015
Policy Expiration Date:	October 20, 2060
Face Amount:	$500,000
Initial Level Premium Period:	20 years
Premium and Premium Frequency at Issue:	$391.23 Quarterly
Final Conversion Date:	October 20, 2035

The Final Conversion Date is the earlier of the Insured's Attained Age 70 and the end of the Initial Level Premium Period.

TABLE OF PREMIUMS

Based on Policy Face Amount

Policy Year	Guaranteed Annual Premium	Policy Year	Guaranteed Annual Premium	Policy Year	Guaranteed Annual Premium
1	$1,490.40	16	$1,490.40	31	$67,945.00
2	1,490.40	17	1,490.40	32	75,915.00
3	1,490.40	18	1,490.40	33	84,215.00
4	1,490.40	19	1,490.40	34	93,165.00
5	1,490.40	20	1,490.40	35	103,075.00
6	1,490.40	21	24,175.00	36	114,145.00
7	1,490.40	22	26,535.00	37	126,415.00
8	1,490.40	23	29,635.00	38	139,815.00
9	1,490.40	24	32,905.00	39	154,175.00
10	1,490.40	25	36,345.00	40	169,325.00
11	1,490.40	26	40,105.00	41	185,135.00
12	1,490.40	27	44,205.00	42	200,005.00
13	1,490.40	28	48,965.00	43	215,505.00
14	1,490.40	29	54,525.00	44	231,855.00
15	1,490.40	30	60,945.00	45	249,125.00

Premiums for any additional riders attached to this policy will be in addition to the premiums shown above.
All premiums shown include an annual policy fee of: $75.00

There is an additional charge for premium frequencies other than annual. This charge is based on the following premium frequency factors:
Semi-annual: .5125 of annual premium
Quarterly: .2625 of annual premium
Pre-Authorized Withdrawal: .0875 of annual premium

DEFINITIONS IN THIS POLICY

All of the following defined terms and phrases and certain items on Your Data Pages are capitalized throughout the policy. Please read them carefully as they will help You understand the policy provisions.

ATTAINED AGE means the Insured's age on the birthday nearest to the Policy Date, plus the number of complete Policy Years that have elapsed since the Policy Date.

DATA PAGES are the pages of this policy which contain information specific to You, to the Insured and the policy. Current or revised Data Pages may be sent to You from time to time which reflect the current status of Your policy.

EFFECTIVE DATE is the date on which all requirements for issuance of a policy have been satisfied.

FACE AMOUNT is the amount used to determine the death benefit provided by the policy. The Face Amount is shown on the Data Pages.

HOME OFFICE is the address shown on Your policy cover page or such other address We provide.

INITIAL LEVEL PREMIUM PERIOD is the number of Policy Years from the Policy Date during which the premium remains level. The Initial Level Premium Period is shown on the Data Pages.

INSURED is the person named as the Insured on the Data Pages of the policy. The Insured may or may not be the owner.

MONTHLY DATE is the day of the month which is the same as the day of the Policy Date. The Monthly Date will never be the 29th, 30th, or 31st of any month.

NOTICE is a communication that is acceptable to Us in form and substance and that We receive in Our Home Office. We will require You to use a form We provide for certain Notices, including, for example, a policy surrender, a change of beneficiary, or a request to adjust Your policy.

POLICY DATE is the date from which Monthly Dates, Policy Years, and policy anniversaries are determined. The Policy Date is shown on the Data Pages. The Policy Date will never be the 29th, 30th, or 31st of any month.

POLICY YEAR is the one year period beginning on the Policy Date and ending one day before the policy anniversary and each subsequent one year period beginning on a policy anniversary.

> Example: If the Policy Date is November 21, 2013, the first Policy Year ends on November 20, 2014. The first policy anniversary falls on November 21, 2014.

WE, OUR, US, THE COMPANY is Principal National Life Insurance Company.

YOU, YOUR is the owner(s) of this policy.

PURCHASING AND KEEPING THE POLICY IN FORCE

PREMIUM PAYMENTS

Your first premium must be paid in advance of the policy becoming effective and is due on the Policy Date. After that, future premium due dates are determined by the frequency You select.

1. Annual premiums are due on the first day of each Policy Year.
2. Semi-annual premiums are due on the first day of each Policy Year and six months thereafter.
3. Quarterly premiums are due on the first day of each Policy Year and every three months thereafter.
4. Pre-authorized withdrawal premiums are due on the same day in each month as the Policy Date.

You may change the frequency of the premium payments with Our approval. However, if You choose a premium payment frequency other than annual, an additional charge, as shown on the Data Page, will apply over and above the guaranteed annual premium.

Premiums are payable when due. All premiums are to be sent to the address We provide in Your premium notice. We will give a receipt to You on request.

PREMIUM CHANGES

Premiums during the Initial Level Premium Period, excluding rider premiums, are listed in the Table of Premiums on Your Data Pages and will not change.

Premiums following the Initial Level Premium Period, excluding rider premiums, may change but will never be greater than the premiums listed in the Table of Premiums. Any such change in the premiums:

1. will be effective on the policy anniversary next following the date We mail the notice to You;
2. will be made on a uniform basis for insureds having the same plan, age at issue, Policy Date, gender where applicable, risk class, and tobacco status;
3. will be based on Our expectation as to Our future investment earnings, expenses, state and federal taxes, mortality and persistency experience, market conditions, and revenue for profit; and
4. will not apply to any riders attached to this policy, unless the rider provides for an increase or decrease in premiums.

GRACE PERIOD

Except for the first premium, a grace period of 31 days will be allowed for the payment of each premium. If a premium is not received in Our Home Office when due, Your policy will enter a grace period. We will mail a notice of impending policy termination to You at Your last address known to Us and to any assignee on record at least 30 days prior to termination. This notice will tell You the required premium, payment instructions and the grace period end date. If, by the end of the grace period, You have not paid to Our Home Office the required premium, Your policy, including privileges and rights of the owner(s), will terminate effective on the premium due date.

If the Insured dies during a grace period, We will pay the death proceeds to the beneficiary(ies) subject to the Death Proceeds section of this policy. Any pro rata premium due will be deducted from the death proceeds.

TERMINATION

All Your policy privileges and rights under this policy terminate on the date:

1. the Insured dies; or
2. the policy expires, or is converted; or
3. premiums are due and unpaid as described in the Grace Period provision; or
4. We receive Your Notice to cancel it.

REINSTATEMENT

If Your policy terminates as described in the Grace Period provision, You may reinstate it, although possibly at a different risk class, provided:

1. such reinstatement is prior to the Policy Expiration Date as shown on the Data Pages;
2. not more than three years have elapsed since Your policy terminated;
3. You supply evidence which satisfies Us that the Insured is alive and insurable under Our underwriting guidelines then in effect; and
4. You pay all past due premiums. We reserve the right to charge interest on past due premiums at 6% compounded annually from their respective due dates.

Reinstatement will be effective on the Monthly Date on or next following the date We approve it. Your Policy Date will remain the original Policy Date. Upon reinstatement, We will send You Data Pages that reflect the current status of Your policy.

RENEWAL PRIVILEGE

You may renew this policy without evidence of insurability for successive one year periods for the premium shown in the Table of Premiums on the Data Pages. No period of renewal may extend beyond the Policy Expiration Date shown on the Data Pages.

Renewal will be effective upon payment of the required premium on or before its due date or during the grace period.

CONVERSION PRIVILEGE

This policy may be converted in whole or in part, without evidence of insurability, by submitting a Notice requesting conversion any time before the Final Conversion Date shown on Your Data Pages. The conversion will be allowed provided this policy is in force and is not in a grace period.

THE NEW POLICY

The Face Amount of the new policy:

1. may not exceed the Face Amount of this policy; and
2. may not be less than the minimum Face Amount allowed for the policy selected, according to Our underwriting guidelines then in effect.

Premiums and values for the new policy will be based on:

1. a risk class most comparable to the risk class of this policy;
2. rates in effect on the date of the conversion; and
3. the Insured's Attained Age on the date of conversion.

The new policy will be any form of life insurance policy, except term insurance, available under Our underwriting guidelines then in effect. The first premium for the new policy must be paid in advance of the policy becoming effective and is due on the new policy's Effective Date. The periods specified in the Suicide and Incontestability provisions will not begin again for the new policy, and will be measured from the Effective Date of this policy. If the new policy is not accepted, we will restore the Face Amount of Your policy to the Face Amount that existed prior to the conversion.

The date of conversion and the new policy's Effective Date will be the date We approve the Notice for conversion.

RIDERS

Any riders on this policy will cease upon conversion. Similar riders may be issued with the new policy without evidence of insurability, subject to the provisions in the new riders and subject to Our rules in effect on the date of conversion. The following conditions must be satisfied:

1. the rider is on this policy; and
2. the rider is available at the Attained Age of the Insured on the new policy's Policy Date; and
3. premiums are not being waived due to the Insured's disability under a similar rider on this policy.

DEATH PROCEEDS

We will pay the death proceeds to the beneficiary(ies) subject to the provisions of the policy, after We receive:

1. Notice and due proof that the Insured died while the policy was in force and prior to the Policy Expiration Date; Due proof of the Insured's death consists of a certified copy of the death certificate of the Insured; and
2. sufficient information to determine Our liability, the extent of the liability and the appropriate payee legally entitled to the proceeds; and
3. sufficient evidence that any legal impediments to payment of proceeds that depend on the action of parties other than Us are resolved. Legal impediments to payment include, but are not limited to (a) the establishment of guardianships and conservatorships; (b) the appointment and qualification of trustees, executors and administrators; and (c) the submission of information required to satisfy state and federal reporting requirements.

We require notification of the Insured's death as soon as it occurs, or as soon thereafter as is reasonably possible. The death proceeds, determined as of the date of the Insured's death, will be:

A the Face Amount of this policy as shown on the Data Pages; plus
B death proceeds from any benefit rider on the Insured's life; plus
C any premium paid and applied beyond the month in which the death occurred; less
D any pro rata premium due.

Any premium received after the date of death will be paid to the beneficiary(ies) and will not be included in the calculation of the death proceeds. With Our consent a different arrangement for return of premium may be specified prior to the payment of death proceeds.

Interest on death proceeds shall accrue and be payable from the date of death. Interest shall accrue at the rate or rates applicable to the policy for funds left on deposit. In determining the effective annual rate or rates, We will use the rate in effect on the date of death.

Interest shall accrue at the effective annual rate determined in the previous paragraph, plus additional interest at a rate of 10% annually beginning with the date that is 31 calendar days from the latest of Our receipt of items 1, 2, and 3 above to the date the claim is paid.

BENEFIT PAYMENT OPTIONS

In lieu of a lump sum payment, You may elect a benefit payment option for payment of the death proceeds. If no benefit payment option has been elected before the Insured's death, the beneficiary may apply the death proceeds to a benefit payment option.

Once the proceeds are applied under a benefit payment option, this policy is terminated and a supplementary contract is issued. The Company reserves the right, as its discretion, to provide a supplementary contract issued by itself, by an affiliated company, or by a non-affiliated issuer of annuity contracts.

BENEFIT PAYMENT CONDITIONS

Election of any benefit payment option is subject to the following conditions:

1. Any amount payable to an assignee will be paid in one lump sum. Any remaining proceeds will then be applied to the elected benefit payment option.
2. No changes may be made to the benefit payment option once a supplementary contract is issued.
3. The proceeds applied must be at least $25,000.00.
4. Benefit payment options are restricted if the recipient of benefits is not a natural person.
5. We reserve the right to require evidence of age, gender where applicable, and continuing survival.
6. Under Options B, C, D, and E, one of the persons on whose life payments are based must be the owner, Insured, or beneficiary.

DESCRIPTION OF BENEFIT PAYMENT OPTIONS

OPTION A, CUSTOM: A custom benefit arrangement can be designed with the Company's written approval.

OPTION B, LIFE INCOME: We will make benefit payments during the person's lifetime. Payments cease when the person dies.

OPTION C, LIFE INCOME WITH GUARANTEED PERIOD: We will make benefit payments for the longer of the person's lifetime or a guaranteed period that You select. If the person dies after payments begin but before the end of the guaranteed period, the remaining payments will be paid to the named beneficiary(ies) under the benefit payment option.

OPTION D, JOINT AND SURVIVOR LIFE INCOME: We will make benefit payments during the lifetime of two persons. Payments cease when both persons have died.

OPTION E, JOINT AND SURVIVOR LIFE INCOME WITH GUARANTEED PERIOD: We will make benefit payments for the longer of the lifetimes of two persons or a guaranteed period that You select. If both persons die after payments begin but before the end of the guaranteed period, the remaining payments will be paid to the named beneficiary(ies) under the benefit payment option.

BENEFIT OPTIONS B, C, D, and E: Benefit payments will be in an amount We determine but not less than guaranteed by this section. The minimum amount of benefit payments will be determined using the 2012 Individual Annuity Mortality Period Life Table with mortality projected on a full generation basis using Projection Scale G2 and 1% interest.

Benefit payments at the time of their commencement will not be less than those that would be provided by the application of the death proceeds to purchase a single consideration immediate annuity contract at purchase rates offered by Us at the time to the same class of annuitants whether the annuity benefits are payable in fixed or variable amounts or both.

Benefit payments are based on the year of annuity commencement, age and gender of the payee except where prohibited by state or federal laws.

OWNER, BENEFICIARY, ASSIGNMENT

OWNER

The owner(s) is as named in the application unless You change ownership as provided in the Change of Owner Or Beneficiary provision. As owner(s), You may exercise every right and privilege provided by Your policy, subject to the rights of any irrevocable beneficiary(ies). Your ownership rights and privileges continue while Your policy is in force. If an owner dies before the policy terminates, the surviving owner(s), if any, shall succeed to that person's ownership interest, unless otherwise specified. If all owners die before the policy terminates, the policy will pass to the Insured. With Our consent You may specify a different arrangement for contingent ownership.

BENEFICIARY

The beneficiary(ies) named in the application will receive the death proceeds unless You change the beneficiary designation as provided in the Change of Owner Or Beneficiary provision. If any beneficiary dies before the Insured, We will pay the death proceeds to any surviving beneficiary(ies) according to terms of the beneficiary designation then in effect. If no beneficiary(ies) survives the Insured, the death proceeds will be paid to the surviving owner(s) in equal percentages or, if applicable, to the last surviving owner's estate unless otherwise specified.

If the beneficiary is not a natural person, We may require proof the beneficiary is a validly existing entity immediately prior to making payment but no later than 180 days following the death of the Insured. If proof cannot be provided, then the beneficiary will be deemed to NOT have survived the Insured's death.

CHANGE OF OWNER OR BENEFICIARY

You may change the owner(s) or beneficiary(ies) of this policy by sending Us Notice. The beneficiary designation cannot be changed without the consent of any irrevocable beneficiary(ies). Unless otherwise specified by You, the change is effective as of the date You signed the Notice. However, the rights of the beneficiary and new Owner are subordinate to any payments made or actions taken by Us prior to Our receipt of the Notice. We may require that You send Us this policy so We can record the change. We may restrict changes in ownership in order to satisfy applicable laws or regulations.

BENEFIT INSTRUCTIONS

While the Insured is alive, You may send Us instructions for the payment of the death proceeds under one of the benefit payment options. Such instructions, or change of instructions, must be in a format We specify. We must receive and process the arrangement You choose before any payment is made. If You change beneficiary(ies), prior benefit instructions are revoked.

ASSIGNMENT

You may assign Your policy by providing Us with an original or a certified copy of the assignment which must be in a form acceptable to Us. We assume no responsibility for the assignment's validity. An assignment does not change the ownership of the policy. The rights of beneficiaries, whenever named, except for irrevocable beneficiaries named prior to Our receipt in Our Home Office of the assignment, become subordinate to those of the assignee. Unless otherwise specified by You, the assignment becomes effective on the date the Notice of assignment is signed. However, the rights of the assignee are subordinate to any payments made or actions taken by Us prior to Our receipt of the Notice of assignment. We may restrict assignments in order to satisfy applicable laws or regulations.

GENERAL INFORMATION

ADJUSTMENTS

The policy Face Amount may be decreased as a result of a partial conversion. You may request a risk class change subject to Our underwriting guidelines then in effect.

THE CONTRACT

This policy, the attached application(s) and riders or endorsements, any amendments to the application(s), any adjustment and reinstatement application(s), and the Data Pages make up the entire contract. If We send You revised Data Pages, the Data Pages are to be attached to and made a part of this policy. Where revised Data Pages conflict with the previously issued Data Pages, the revised Data Pages will govern. All statements made in the application(s), an adjustment application(s), or any amendments to the application(s) will be considered representations and not warranties. No statement, unless made in an application(s), or amendments thereto, will be used to void Your policy (or void an adjustment in case of an adjustment application(s)) or to defend against a claim.

ALTERATIONS

This policy may be altered by mutual agreement between You and The Company, or as necessary to comply with applicable law. Any alteration must be in writing and signed by one of Our corporate officers. No one else, including the agent, may change the policy or waive any provisions.

INCONTESTABILITY

With respect to material misstatements made in the initial application(s) for this policy, We will not contest this policy after the policy has been in force during the lifetime of the Insured for two years from the Policy Date. With respect to material misstatements made in any subsequent application(s) or reinstatement application(s), We will not contest the coverage resulting from such application(s) after the coverage has been in force during the lifetime of the Insured for two years after the date of the change. The time limits in this Incontestability provision do not apply to fraudulent misrepresentations, when permitted by applicable law in the state where this policy is delivered or issued for delivery, or to any attached rider that provides benefits in the event of total disability.

MISSTATEMENT OF AGE OR GENDER

If the age, or gender where applicable, of the Insured has been misstated, the death benefit will be the amount the premium would have purchased at the correct age, or gender where applicable, of the Insured.

SUICIDE

This policy's death proceeds will not be paid if the Insured dies by suicide, while sane or insane, within two years of the Policy Date. Instead, We will return all premiums paid. This amount will be paid to the beneficiary(ies) of the policy.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

This policy was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this policy that on the provision's effective date is in conflict with Interstate Insurance Product Regulation Commission standards for this product type is hereby amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

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Principal Financial Group

Principal Life Insurance Company
Principal National Life Insurance Company
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P.O. Box 10431
Des Moines, IA 50306-0431

Amendment to Application

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

NOTE This form MUST be returned to the Home Office fully signed and dated.

Policy No.: 4855776 Insured: George T Campbell III

The Application for the above Policy (or for its adjustment or reinstatement) is hereby amended as follows:
With beneficiary designation amended as follows: Larissa Kiers, ex-spouse, if living, otherwise to Tracey Cote, fiance.
With application amended to show response to question 3A on Teleapp is June 2013.
With application amended to show response to question 3C on Teleapp is May 2014, last nicotine gum use
With application amended to show response to question 7C on Part A is no.
With plan of insurance to be Twenty Year Term.

By signing below, I agree that all amendments to the Application listed above are part of the Application, and the Application and the amendments are to be taken as a whole. It is agreed that the above Policy is issued (or adjusted or reinstated, as applicable) on the basis of the statements in the Application and in this Amendment and Acceptance Form.

To be signed and dated by the person(s) indicated below:

☐ Policyowner: _____ ☐ Insured: _____

Date: 10/22/2015

Principal Financial Group

☐ **Principal Life Insurance Company**
☑ **Principal National Life Insurance Company**
Members of Principal Financial Group®

P.O. Box 10431
Des Moines, IA 50306-0431

Life Insurance Application

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

PART A

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

Name (First, Middle, Last)	Sex	Date of Birth
George T Campbell III	☑ Male ☐ Female	04 / 22 / 1965
Primary Residence Street Address	**Social Security Number**	**Birthplace (State, or Country if not U.S.)**
15 McKinley Street	003 - 62 - 2967	Boston, MA
City, State, Zip Code	**Driver's License Number**	**State Issued**
Concord, NH 03301	04CLG65221	NH
Home Phone Number	**Occupation**	
(603) 770-0167	Atty	
Work Phone Number	**Workplace Zip Code**	
(603) 668-7272	03105	

411

2. BASIC COVERAGE APPLIED FOR

Product Principal National L-Fe 20

Face Amount (excluding riders)
$ 500,000

Death Benefit Option if applicable:
- ☐ Option 1: Level Face Amount
- ☐ Option 2: Face + Accumulated/Policy Value
- ☐ Option 3: Face + Premiums Paid Less Partial Surrenders

Policy Planned Premium $ 162.97

Premium Frequency: (choose one)
☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Single Pay

☑ EFT (complete EFT form + attach sample check)

List Bill Number _____
☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly

Unscheduled Premium $ _____

3. BENEFITS/RIDERS (Some riders are not available with all products)

- ☐ Accidental Death – Amount $ _____
- ☐ Accounting Benefit
- ☐ Alternate Cash Surrender Value
- ☐ Change of Insured
- ☐ Children Term – Amount $ _____
- ☐ Four Year Term
- ☐ 20 Year Premium Guarantee
- ☐ Policy Split Option
- ☐ Salary Increase – Amount $ _____
- ☐ Single Life Term – Amount $ _____
- ☐ Waiver of Premium/Specified Premium
- ☐ Waiver of Monthly Deductions/Monthly Policy Charges
- ☐ _____
- ☐ _____

4. BENEFICIARY INFORMATION

Primary Beneficiary	Relationship to Proposed Insured
Larissa Kiers	Ex-Spouse
Contingent Beneficiary	**Relationship to Proposed Insured**
Tracey Cote	Friend
Single Life Term Rider Beneficiary	**Relationship to Proposed Insured**

Proposed Insured Name	George T Campbell III

5. OWNERSHIP INFORMATION (Complete if different than the Insured)

Owner Name (If trust, provide name of trust*)	Relationship to Proposed Insured
George T Campbell ID	Insured
Primary Residence Street Address	Taxpayer Identification Number
15 McKinley Street	003-62-9267
City, State, Zip Code	Date of Birth (If trust, provide date of trust*)
Concord, NH 03301	04/22/1965
Joint Owner Name	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth
Contingent Owner Name	Relationship to Proposed Insured

*** Submit copy of trust with this application.**

6. CHANGE OF OWNERSHIP

(a) Is there an intention that any group of investors will obtain any right, title, or interest in any policy issued on the life of the Proposed Insured(s) as a result of this application? ☐ Yes ☒ No
If yes, explain.

(b) Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you in return for an assignment of policy values back to them? ☐ Yes ☒ No
If yes, explain and complete premium financing acknowledgment form.

7. OTHER INSURANCE

(a) Is there other life insurance or annuities in force or applied for? ☐ Yes ☒ No
(If yes, list all other life insurance or annuities in force or currently being applied for, even if sold, assigned, or viaticated.)

Insured's Name	Company	Amount	Policy Number	Check if Pending	Year Issued	Primary Purpose
		$		☐		
		$		☐		
		$		☐		
		$		☐		

(b) If coverage is pending, will all pending coverage be accepted? ☐ Yes ☐ No
If no, explain.

(c) Have you transferred or assigned any right, title, or interest in any life insurance or annuity contract other than absolute assignment for Internal Revenue Code 1035 exchange? ☐ Yes ☐ No
If yes, explain.

8. REPLACEMENT

(a) Will the insurance applied for with this application replace or affect any of the owner's other life or annuity contracts (including pending coverage provided with a binding receipt)? ☐ Yes ☒ No
If yes, list company name(s) and policy number(s) and provide necessary forms:

(b) Is this an Internal Revenue Code section 1035 exchange? ☐ Yes ☒ No

Proposed Insured Name George T Campbell III

9. MEDICAL QUESTION

Within the last ten years, has the Proposed Insured been treated for, or diagnosed by a member of the medical profession as having a heart condition, chest pain, stroke, cancer, diabetes, alcohol abuse or drug dependency? ☐ Yes ☒ No
(If yes, explain below.)

Details (including dates and healthcare provider's name/address)

(Continue to next page)

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Principal Life Insurance Company
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P.O. Box 10431
Des Moines, IA 50306-0431

Insurance Application

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Proposed Insured George T Campbell III
D.O.B. 04 / 22 / 1965 Policy Number (If known) _____

PART B
All references to "you" mean the Proposed Insured.

ACTIVITIES/HEALTH HABITS

1. In the last five years have you, or do you have plans to:
   a. be a member of any armed forces or military unit? ☐ Yes ☑ No
   b. pilot any type of aircraft? ☐ Yes ☑ No
   c. engage in scuba/skin diving, motor vehicle racing, skydiving or any other hazardous sporting activity? ☐ Yes ☑ No
   d. live outside the United States or Canada? (If yes, explain below) ☐ Yes ☑ No
   e. travel outside the United States or Canada? (If yes, explain below) ☐ Yes ☑ No
2. In the last five years have you:
   a. been in a motor vehicle accident, been convicted of or plead guilty to driving while intoxicated or had more than one moving violation? (If yes, explain below) ☐ Yes ☑ No
   b. been on parole or probation or charged with a felony or misdemeanor? (If yes, explain below) ☐ Yes ☑ No
3. In the last ten years have you used any tobacco or nicotine products? ☑ Yes ☐ No
   (Indicate date last used and amount per day)
   a. ☑ cigarettes 06/2013
   b. ☐ cigars _____
   c. ☑ nicotine patch/gum 05/2014
   d. ☐ pipe _____
   e. ☐ chewing tobacco/snuff _____
   f. ☐ other _____
4. In the last ten years have you consumed alcoholic beverages? ☑ Yes ☐ No
   If yes, date last used? 06/24/2015 Number of drinks per week: 3
5. In the last ten years have you used cocaine, marijuana, methamphetamines, barbiturates or other controlled substances? ☐ Yes ☑ No
6. Have you ever been advised to limit or discontinue the use of alcohol or drugs; or sought or received treatment because of your alcohol or drug use? ☐ Yes ☑ No

DETAILS TO QUESTIONS 1-6

Quest. #	Include dates and details as requested above.

Principal Financial Group

Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group®

P.O. Box 10431
Des Moines, IA 50306-0431

Insurance Application

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

Proposed Insured George T Campbell III
D.O.B. 04 / 22 / 1965 Policy Number (If known) _____

PART B – (Continued)

INCOME/OCCUPATION
For Life, complete questions 7 and 8. For DI, complete questions 8-17. In all cases, Part B continues on the next page.

7. Annual income from occupation $ 130,000 Other Income $ —
   Source of other income _____ Net Worth (Assets – Liabilities) $ _____
8. Primary occupation Atty Employer Backus, Mehtri Branch LL
9. Current Employment Information
   a. Type of business or industry Legal Services
   b. Job title Attorney
   c. What are your job activities and percentage of time spent in each? Client contact 33 1/3% Research & Writing 33 1/3% Court 33 1/3%
   d. How many hours do you usually work per week in your primary job? 45
   e. Total number of employees: Full-time 15 Part-time _____ Sub-contracted _____
   f. How many employees do you supervise? _____
10. How long have you been employed by your current employer? 2 (If less than three years, provide details below, e.g., employers, occupations and dates for last five years.)
11. Do you work out of your home? (If yes, how many hours per week? _____) ☐ Yes ☒ No
12. Do you have any other part-time or full-time jobs? (If yes, explain below) ..... ☐ Yes ☒ No
13. Are you actively at work on a full-time basis without medical restriction? (If no, explain below) ..... ☒ Yes ☐ No
14. Do you intend to change jobs or employment in the next 6 months? (If yes, explain below) ..... ☐ Yes ☒ No
15. Have you ever requested or received any type of disability benefits (including workers' compensation and state disability) for an injury or illness? (If yes, explain below) ..... ☐ Yes ☒ No
16. Do you have an ownership interest in any business you work for? ..... ☐ Yes ☒ No
    If yes, ownership percentage _____ length of ownership _____
    Type of business: ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Limited Liability Company ☒ Other LLP
17. Have you, or any business owned in whole or part by you, ever been in bankruptcy or any similar proceedings? (If yes, provide date discharged, type and chapter) ..... ☐ Yes ☒ No

DETAILS TO QUESTIONS 7-17

Quest. #	Include dates and details as requested above.
10.	Stein Law Firm, Concord, NH

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Proposed Insured George T. Campbell III
D.O.B. 04 / 22 / 1965 Policy Number (If known) _____

PART B – (Continued)

MEDICAL HISTORY (Provide details to yes answers, questions 18-20 below)

18. In the last ten years, have you been treated for or been diagnosed by a member of the medical profession as having:
    a. high blood pressure, heart attack, chest pain, heart murmur, irregular heart beat, stroke, or any other disease or disorder of the heart or blood vessels? ☐ Yes ☒ No
    b. cancer or a tumor, cyst or growth? ☐ Yes ☒ No
    c. asthma, bronchitis, emphysema, tuberculosis or any other disease or disorder of the lungs or respiratory system? ☒ Yes ☐ No
    d. seizure, paralysis, headaches, multiple sclerosis or any other disease or disorder of the brain or nervous system? ☐ Yes ☒ No
    e. chronic fatigue, stress, depression, anxiety or any other emotional or psychological disorder? ☐ Yes ☒ No
    f. hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract? ☐ Yes ☒ No
    g. diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system? ☐ Yes ☒ No
    h. kidney stones, nephritis, any blood or protein in the urine, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system? ☐ Yes ☒ No
    i. back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, carpal tunnel syndrome, or any other disease or disorder of the bones, joints, or muscles? ☐ Yes ☒ No
    j. any disease or disorder of the eyes, ears, nose, throat or skin? ☐ Yes ☒ No
19. (DI Only) Are you currently pregnant or have you been treated for complications of pregnancy in the last ten years? ☐ Yes ☒ No
20. In the last ten years, have you been treated for or been diagnosed by a member of the medical profession as having HIV (Human Immunodeficiency Virus) infection, positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)? ☐ Yes ☒ No

DETAILS TO QUESTIONS 18-20

Quest. #	For yes answers, include dates, details, diagnosis, types and results of treatment, healthcare provider's full name and address.
18c)	Mild asthma, advair & albuterol. Doesn't currently use.

Proposed Insured George T Campbell III
D.O.B. 04 / 22 / 1965 Policy Number (If known) _____

PART B – (Continued)

MEDICAL HISTORY (Provide details to yes answers, questions 21-26 below)

21. Who is your Primary Physician? ☐ None
    a. Name: Kelly Seicheprine MD — Phone Number: (603) 224-4003
    Street: 248 Pleasant View Ave #1000 — City: Concord — State: NH — Zip: 03301
    b. Date last seen, reason and details: 03/2014 Physical

22. In the last ten years:
    a. have you had any medical tests, hospitalization, illness or injury not provided in response to a previous question? (If yes, explain below) ☐ Yes ☒ No
    b. have you consulted a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question? (If yes, explain below) ☒ Yes ☐ No

23. Are you taking or have you been advised by a member of the medical profession to take any medication or treatment not provided in response to a previous question? (If yes, explain below) ☐ Yes ☒ No

24. Current Ht. 5'10" Wt. 175 Have you lost more than 10 lbs. in the last year? ☐ Yes ☒ No
    If yes, _____ lbs./kgs. Indicate reason _____

25. a. Has either of your natural parents lived to at least age 60? ☐ Yes ☐ No
    b. Do any of your natural parents or siblings have a history of diabetes, cancer, stroke or heart disease? ☐ Yes ☐ No
    If yes, provide details (i.e., relationship, type of disease, age diagnosed, current age or age at death):
    Adopted.

26. Have you ever had any life, health or disability insurance rated, ridered or declined? (If yes, explain below) ☐ Yes ☒ No

DETAILS TO QUESTIONS 21-26

Quest. #	Include dates and details as requested above.
22b.	Psychologist - Robert Shuke, Concord, NH
	07/2014 – 01/2015
	Dealing with 6 yr old daughter's leukemia.
	No follow up
25a.)	Adopted. Doesn't know history.

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Proposed Insured GEORGE CAMPBELL III

D.O.B. 04 / 22 / 1965 Policy Number (If known) _____

PART B

All references to "you" mean the Proposed Insured.

ACTIVITIES/HEALTH HABITS

1. In the last five years have you, or do you have plans to:
   a. be a member of any armed forces or military unit? ☐ Yes ☒ No
   b. pilot any type of aircraft? ☐ Yes ☒ No
   c. engage in scuba/skin diving, motor vehicle racing, skydiving or any other hazardous sporting activity? ☐ Yes ☒ No
   d. live outside the United States or Canada? (If yes, explain below) ☐ Yes ☒ No
   e. travel outside the United States or Canada? (If yes, explain below) ☐ Yes ☒ No
2. In the last five years have you:
   a. been in a motor vehicle accident, been convicted of or plead guilty to driving while intoxicated or had more than one moving violation? (If yes, explain below) ☐ Yes ☒ No
   b. been on parole or probation or charged with a felony or misdemeanor? (If yes, explain below) ☐ Yes ☒ No
3. In the last ten years have you used any tobacco or nicotine products? ☒ Yes ☐ No
   (Indicate date last used and amount per day)
   a. ☒ cigarettes see details
   b. ☐ cigars _____
   c. ☐ nicotine patch/gum _____
   d. ☐ pipe _____
   e. ☐ chewing tobacco/snuff _____
   f. ☐ other _____
4. In the last ten years have you consumed alcoholic beverages? ☒ Yes ☐ No
   If yes, date last used? 2015 Number of drinks per week: 7
5. In the last ten years have you used cocaine, marijuana, methamphetamines, barbiturates or other controlled substances? ☐ Yes ☒ No
6. Have you ever been advised to limit or discontinue the use of alcohol or drugs; or sought or received treatment because of your alcohol or drug use? ☐ Yes ☒ No

DETAILS TO QUESTIONS 1-6

Quest. #	Include dates and details as requested above.
3	Additional details: CLIENT SMOKED 5 TO 10 CIGARETTES PER DAY.
3A	CIGARETTES; JUNE, 2012; 10 per day
4	Additional details: CLIENT HAS 5 TO 7 DRINKS PER WEEK.

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Proposed Insured GEORGE CAMPBELL III

D.O.B. 04 / 22 / 1965 Policy Number (If known) _____

PART B – (Continued)

INCOME/OCCUPATION

For Life, complete questions 7 and 8. For DI, complete questions 8-17. In all cases, Part B continues on the next page.

7. Annual income from occupation $ 130,000 Other Income $ none
   Source of other income N/A Net Worth (Assets – Liabilities) $ 200,000
8. Primary occupation ATTORNEY Employer see details
9. Current Employment Information
   a. Type of business or industry _____
   b. Job title _____
   c. What are your job activities and percentage of time spent in each?

   d. How many hours do you usually work per week in your primary job? _____
   e. Total number of employees: Full-time _____ Part-time _____ Sub-contracted _____
   f. How many employees do you supervise? _____
10. How long have you been employed by your current employer? _____ (If less than three years, provide details below, e.g., employers, occupations and dates for last five years.)
11. Do you work out of your home? (If yes, how many hours per week? _____) NA ☐ Yes ☐ No
12. Do you have any other part-time or full-time jobs? (If yes, explain below) ..... NA ☐ Yes ☐ No
13. Are you actively at work on a full-time basis without medical restriction? (If no, explain below) ..... NA ☐ Yes ☐ No
14. Do you intend to change jobs or employment in the next 6 months? (If yes, explain below)..... NA ☐ Yes ☐ No
15. Have you ever requested or received any type of disability benefits (including workers' compensation and state disability) for an injury or illness? (If yes, explain below)..... NA ☐ Yes ☐ No
16. Do you have an ownership interest in any business you work for?..... NA ☐ Yes ☐ No
    If yes, ownership percentage _____ length of ownership _____
    Type of business: ☐ C Corporation ☐ S Corporation ☐ Partnership
    ☐ Sole Proprietorship ☐ Limited Liability Company ☐ Other _____
17. Have you, or any business owned in whole or part by you, ever been in bankruptcy or any similar proceedings? (If yes, provide date discharged, type and chapter)..... NA ☐ Yes ☐ No

DETAILS TO QUESTIONS 7-17

Quest. #	Include dates and details as requested above.
7	Additional details: CLIENTS ANNUAL INCOME IS APPROXIMATE AND VARIES. CLIENTS NET WORTH IS 100,000 TO 200,000.
8	BACKUS MEYER AND BRANCH

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Proposed Insured GEORGE CAMPBELL III

D.O.B. 04 / 22 / 1965 Policy Number (If known) _____

PART B – (Continued)
MEDICAL HISTORY (Provide details to yes answers, questions 18-20 below)

18. In the last ten years, have you been treated for or been diagnosed by a member of the medical profession as having:
    a. high blood pressure, heart attack, chest pain, heart murmur, irregular heart beat, stroke, or any other disease or disorder of the heart or blood vessels? ☐ Yes ☒ No
    b. cancer or a tumor, cyst or growth? ☐ Yes ☒ No
    c. asthma, bronchitis, emphysema, tuberculosis or any other disease or disorder of the lungs or respiratory system? ☒ Yes ☐ No
    d. seizure, paralysis, headaches, multiple sclerosis or any other disease or disorder of the brain or nervous system? ☐ Yes ☒ No
    e. chronic fatigue, stress, depression, anxiety or any other emotional or psychological disorder? ☐ Yes ☒ No
    f. hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract? ☐ Yes ☒ No
    g. diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system? ☐ Yes ☒ No
    h. kidney stones, nephritis, any blood or protein in the urine, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system? ☐ Yes ☒ No
    i. back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, carpal tunnel syndrome, or any other disease or disorder of the bones, joints, or muscles? ☒ Yes ☐ No
    j. any disease or disorder of the eyes, ears, nose, throat or skin? ☒ Yes ☐ No
19. (DI Only) Are you currently pregnant or have you been treated for complications of pregnancy in the last ten years? NA ☐ Yes ☐ No
20. In the last ten years, have you been treated for or been diagnosed by a member of the medical profession as having HIV (Human Immunodeficiency Virus) infection, positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)? ☐ Yes ☒ No

DETAILS TO QUESTIONS 18-20

Quest. #	For yes answers, include dates, details, diagnosis, types and results of treatment, healthcare provider's full name and address.
	SEE DETAILS AT END OF PART B...

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Proposed Insured GEORGE CAMPBELL III

D.O.B. 04 / 22 / 1965 Policy Number (If known) _____

PART B – (Continued)
MEDICAL HISTORY (Provide details to yes answers, questions 21-26 below)

21. Who is your Primary Physician? ☐ None

a. Name Phone Number

KELLY SEICHEPINE(IM) INTERNAL MEDICINE ASSOCIATES

Street City State Zip

see details

b. Date last seen, reason and details

see details

22. In the last ten years:

a. have you had any medical tests, hospitalization, illness or injury not provided in response to a previous question? (If yes, explain below) ..... ☒ Yes ☐ No

b. have you consulted a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question? (If yes, explain below) ..... ☒ Yes ☐ No

23. Are you taking or have you been advised by a member of the medical profession to take any medication or treatment not provided in response to a previous question? (If yes, explain below) ..... ☐ Yes ☒ No

24. Current Ht 5 ft 9 in Wt 170 lb Have you lost more than 10 lbs. in the last year? ☐ Yes ☒ No

If yes, _____ lbs./kgs. Indicate reason _____

25. a. Has either of your natural parents lived to at least age 60? ..... NA ☐ Yes ☐ No

b. Do any of your natural parents or siblings have a history of diabetes, cancer, stroke or heart disease? ..... NA ☐ Yes ☐ No

If yes, provide details (i.e., relationship, type of disease, age diagnosed, current age or age at death):

_____

_____

26. Have you ever had any life, health or disability insurance rated, ridered or declined? (If yes, explain below) ..... ☐ Yes ☒ No

DETAILS TO QUESTIONS 21-26

Quest. #	Include dates and details as requested above.
21A	248 PLEASANT VIEW AVE, STE 2800, PH 603-224-4003, CONCORD, NH 03301
21B	March, 2014; CHECK UP; Medical condition that prompted check-up: ROUTINE ANNUAL PHYSICAL; Any diagnostic tests done.: NO; Results of testing: NORMAL; Additional treatment advised.: NO SEE DETAILS AT END OF PART B...

Proposed Insured GEORGE CAMPBELL III

D.O.B. 04 / 22 / 1965 Policy Number (If known)

Quest. #	Include dates and details as requested.
18C	ASTHMA; Doctor/medical facility: CONCORD INTERNAL MEDICINE; 248 PLEASANT ST, STE 2800, PH 603-224-4003, CONCORD, NH 03301; Date last seen: MARCH, 2014; Ever Hospitalized or had surgery.: NO; Date diagnosed/first symptoms: FALL, 1978; Date of last symptoms: 2013; Frequency of shortness of breath, wheezing or other symptoms: 0 TIMES PER YEAR; Current medications/treatments: NONE; Steroids or cortizone in the last five years.: YES; Name of medication: ADVAIR; Date last used: JANUARY, 2015
18C	Additional details: CLIENT IS NO LONGER BEING TREATED FOR THE ASTHMA.
18I	ANKLE, LEFT ANKLE INJURY; LEFT; Doctor/medical facility: CONCORD ORTHOPEDICS; 264 PLEASANT ST, PH 603-224-3368, CONCORD, NH 03301; Date last seen: SUMMER, 2013; Date diagnosed/first symptoms: SUMMER, 2011; Completely recovered: YES
18I	Additional details: CLIENT HAD PHYSICAL THERAPY FOR THE LEFT ANKLE FOR MAYBE 10 SESSIONS.
18J	EXEMA; Doctor/medical facility: CONCORD INTERNAL MEDICINE; 248 PLEASANT ST, STE 2800, PH 603-224-4003, CONCORD, NH 03301; Date last seen: MARCH, 2014; Doctor/medical facility: ANNA RYAN; 1650 ELM ST, STE 101, PH 603-626-7546, MANCHESTER, NH 03101; Date last seen: 2012; Date diagnosed/first symptoms: 1980
18J	TRIAMCINOLONE OINTMENT; Doctor prescribing medication/treatment: CONCORD INTERNAL MEDICINE; 248 PLEASANT ST, STE 2800, PH 603-224-4003, CONCORD, NH 03301; Date last seen: MARCH, 2014; Reason for taking medication/treatment: EXEMA
22A	EKG; Doctor/medical facility: CONCORD INTERNAL MEDICINE; 248 PLEASANT ST, STE 2800, PH 603-224-4003, CONCORD, NH 03301; Date of test: 2013; Test prompted by symptoms or illness.: YES; Medical condition that prompted test: MAYBE CHEST TIGHTNESS OR RIB PAIN; Results of testing: NORMAL; Additional treatment or surgery advised.: NO
22A	Additional details: CLIENT HAD AN EKG OR ECG OR MAYBE BOTH. CLIENT IS NOT SURE.

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Proposed Insured GEORGE CAMPBELL III

D.O.B. 04 / 22 / 1965 Policy Number (If known)

Quest. #	Include dates and details as requested.
22B	COUNSELING, EMOTION COUNSELING; Doctor/medical facility: ROBERT STURKE(PSY); 28 S MAIN ST, PH 603-228-2999, CONCORD, NH 03301; Date last seen: SPRING, 2015; Date diagnosed/first symptoms: SUMMER, 2014; Date of last symptoms: SPRING, 2015; Current medications/treatments: NONE; Missed work due to this condition.: NO; Condition affects daily activities.: NO; Completely recovered: NOT ASKED
22B	Additional details: CLIENT WAS SEEING ROBERT STURKE ONCE A MONTH FOR THE EMOTIONS RELATED TO HIS DAUGHTERS LEUKEMIA DIAGNOSIS. CLIENT IS NO LONGER SEEING THE COUNSELOR.
25A	ADOPTED
25B	ADOPTED

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

AGREEMENT

Statements in Application: I represent that all statements in this application are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name below. I understand and agree that the statements in the application, including statements by the Proposed Insured in any medical questionnaire that becomes a part of this application, shall be the basis of any insurance issued. I also understand that misrepresentations can mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company and that issuer is solely responsible for the obligations under that policy.

When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued as applied for with a premium deposit paid, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner and signing of Part D, if applicable.

I understand and agree that if a policy is issued as other than applied for or without a premium deposit (C.O.D.), then policy coverage is not effective and the Company shall incur no policy liability unless:

1) A policy issued on this application has been physically delivered to and accepted by the owner and the first premium paid; and
2) At the time of such delivery and payment, the person to be insured is actually in the state of health and insurability represented in this application, medical questionnaire, or amendment that becomes a part of this application; and
3) The Part D or the Acknowledgment of Delivery form is signed by me and the Proposed Insured (if different than me) and dated at delivery.

If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy data pages.

Limitation of Authority: I understand and agree that no agent, broker, licensed representative, telephone interviewer, or medical examiner has any authority to determine insurability, or to make, change or discharge any contract, or to waive any of the Company's rights. The Company's right to truthful and complete answers to all questions on this application and on any medical questionnaire that becomes a part of this application may not be waived. No knowledge of any fact on the part of any agent, broker, licensed representative, telephone interviewer, medical examiner or other person shall be considered knowledge of the Company unless such fact is stated in the application.

AUTHORIZATION

I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution or person having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I understand and agree to sign any authorization that is required to authorize any doctor, hospital, clinic, health care provider, laboratory, pharmacy benefit manager or any other institution having personal information (including physical, mental, drug or alcohol use history) regarding the named proposed insured to provide the Company, its representatives or reinsurers any such data. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (CONTINUED)

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company or its representative to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I agree that this authorization shall be valid for 24 months from the date of this application. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. I have received a copy of the "Notice of Insurance Information Practices," which includes notice required by any Fair Credit Reporting Act. It also describes MIB, Inc.

C.O.D. or Advance Premium Paid:

☐ This application is C.O.D. and I have not been given any Conditional Receipt with this application.

☑ I have paid $ 162.47 as an advance premium with this application which is no less than one month's advance premium and I have been given the Life Insurance Conditional Receipt. In return I have read, understand, and agree to its terms.

☐ I have submitted an Absolute Assignment form with this application and I have been given the Life Insurance 1035 Conditional Receipt. In return I have read, understand, and agree to its terms.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

OWNER TAXPAYER IDENTIFICATION NUMBER CERTIFICATION: As proposed owner of this contract, I certify under penalties of perjury: (1) The taxpayer identification number shown on this application is correct, (2) I am not subject to IRS backup withholding, and (3) I am a U.S. person (which includes a U.S. resident alien). If subject to backup withholding complete W-9. If not a U.S. person complete W-8. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Signatures – Please read all of the above Agreements, Authorizations, and Certification before signing below.

Signature of Proposed Insured (If age 15 or over) X				
Signature of Parent (If Proposed Insured is under age 18 and Parent has not signed as Owner) X				
Signature of Owner(s), if other than Proposed Insured. If corporation, an officer other than the Proposed Insured must sign and include officer's title. If joint ownership or Trust, all joint owners/trustees must sign. If signing as a Trustee include 'Trustee' as title.				
X			Title	
X			Title	
X			Title	
Signed at: City Manchester	State NH	Date 09/03/2015	Signature of Licensed Agent/Broker/Representative X	License Number
Cosignature by resident Licensed Agent/Broker/Representative, if applicable in your state X			Date	License Number

Principal Financial Group

☐ Principal Life Insurance Company
☒ Principal National Life Insurance Company
Members of Principal Financial Group®

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

P.O. Box 10431
Des Moines, IA 50306-0431

Life Insurance Application

Proposed Insured George T Campbell III D.O.B. 04 / 22 / 1965

PART D – AGREEMENT/ACKNOWLEDGMENT OF DELIVERY

AGREEMENT: Statements In Application: I have read all the questions and answers obtained during the application process, including Part B on the primary Proposed Insured. I represent all statements are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name below. I have also signed a copy of this Agreement/Acknowledgment of Delivery included with my policy. I understand and agree the statements in the application, including all of its parts and statements by the Proposed Insured in any medical questionnaire or supplement, will be the basis for and form a part of the policy. I understand that misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued as applied for with a premium deposit paid, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner and signing of Part D, if applicable.

I understand and agree that if a policy is issued as other than applied for or without a premium deposit (C.O.D.), then policy coverage is not effective and the Company shall incur no policy liability unless:

1) A policy issued on this application has been physically delivered to and accepted by the owner and the first premium paid; and
2) At the time of such delivery and payment, the person to be insured is actually in the state of health and insurability represented in the application, medical questionnaire, or amendment that becomes a part of this application; and
3) This form is signed by me and the Proposed Insured (if different than me) and dated at delivery.

If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy data pages.

When an Adjustment Becomes Effective: I understand and agree that if I apply to adjust my policy coverage, any adjustment approved by the Company is effective as of the Adjustment Date shown on the new data pages for the policy, provided that I and the proposed insured (if different than me) sign this form and any amendment form, if applicable, and return such forms to the Company within 30 days of the adjustment delivery date.

Limitation of Authority: I understand and agree no agent, broker, licensed representative, telephone interviewer, or medical examiner has any authority to determine insurability, or to make, change or discharge any contract, or to waive any of the Company's rights. The Company's right to truthful and complete answers to all questions on the application and on any medical questionnaire that becomes a part of this application may not be waived. No knowledge of any fact on the part of any agent, broker, licensed representative, telephone interviewer, medical examiner or other person shall be considered knowledge of the Company unless such fact is stated in the application.

ACKNOWLEDGMENT OF DELIVERY:

I acknowledge policy numbered 4855776 was delivered to me today and is based on the life of George T Campbell III .

INSURABILITY DATES:

If a premium deposit was submitted with Part A and C of the application, I verify that all information in Part B of the application is true and complete and is correctly recorded as of 09/22/2015 .

If the application was submitted without a premium deposit (C.O.D.), I verify that all information in the Part A and B of the application including all parts and statements by the Proposed Insured in any medical questionnaire or supplement accurately reflects the Proposed Insured's health and insurability as of the date I sign this form.

SIGNATURES

Signature of Proposed Insured (If age 15 or over)	Signature of Parent (if proposed insured is under age 18 and Parent has not signed as Owner)
X George T Campbell III	X
Signature of Owner(s) (If other than Proposed Insured). If corporation, an officer other than the Proposed Insured must sign, include officer's title. If joint ownership or Trust, all joint owners/trustees must sign, include 'Trustee' after signature.	
X	Title
X	Title
X	Title
Date 10-22-15	

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TERM LIFE INSURANCE POLICY. Benefits payable at the death of the Insured prior to the Policy Expiration Date and while this policy is in force. Premiums are level during the Initial Level Premium Period. After the Initial Level Premium Period, premiums generally increase annually until the Policy Expiration Date, subject to guaranteed maximums. This policy is renewable to the Policy Expiration Date and renewal premiums are payable during continuance of the policy. There is a Conversion Privilege as described in the policy. This policy is non-participating.